



**SIMPONI® (golimumab) - Prior Authorization/Prescription/Patient Enrollment Form**

Complete form in its entirety and fax to number listed below

**PATIENT INFORMATION**

Last Name		First Name		Middle Initial	
Date of Birth		Sex M <input type="checkbox"/> F <input type="checkbox"/>		Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____					
Street Address		City			
State		County		Zip Code	
Home Phone		Cell Phone			
Parent/Guardian		Day Telephone		Night Telephone	
Emergency Contact		Relationship		Telephone	

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**PRESCRIBER INFORMATION**

Prescriber's Name		NPI Number		DEA Number	
Telephone Number		Fax Number		Hospital/Clinic Name	
Street Address		City			
State		County		Zip Code	
Contact Person at Office		Prescriber Specialty			



**Fax Completed Form to:**  
**Fax Number: 800-218-3221**  
**Phone Number: 866-843-3604**

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Department of Vermont Health Access  
**SIMPONI® (golimumab)**  
**PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis: \_\_\_\_\_

Rheumatoid Arthritis  Psoriatic Arthritis  Ankylosing Spondylitis  Ulcerative Colitis

If requesting prescriber is not a Rheumatologist, Dermatologist or Gastroenterologist, has one of these specialties been consulted on this case?  Yes  No

Specialist name: \_\_\_\_\_ Specialist Type: \_\_\_\_\_

Initial Request (please complete remainder of form below)

Subsequent Request: Response/tolerability to Simponi: \_\_\_\_\_

Please explain outcomes of therapy with Enbrel and/or Humira (DVHA preferred products):  
 Therapy (and dates) \_\_\_\_\_ Reason for discontinuation \_\_\_\_\_

List previous medications/therapies tried and failed for this condition:  
 (include NSAIDs, DMARDs, TNF Blockers: oral and injectable)  
 Therapy (and dates) \_\_\_\_\_ Reason for discontinuation \_\_\_\_\_

Prescriber Additional Comments: \_\_\_\_\_

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**PRESCRIPTION**

**Dosage Form and Quantity:**

Simponi 50 mg/0.5 ml  prefilled syringe **OR**  prefilled autoinjector Dispense Qty: 1  
 Sig: Administer 50 mg (1 syringe/autoinjector) subcutaneously once monthly.

Refill X: \_\_\_\_\_ (50 mg dose for RA, PsA or AS)

Simponi 100 mg/1 ml  prefilled syringe **OR**  prefilled autoinjector Dispense Qty: 3 or 1  
 Sig: Loading Dose: Administer 200 mg (2 syringe/autoinjector) subcutaneously at Week 0 and then 100 mg (1 syringe/autoinjector) subcutaneously at Week 2.  
 Sig: Administer 100 mg (1 syringe/autoinjector) subcutaneously once monthly.

Refill X: \_\_\_\_\_

Deliver product to:  Patient's home  MD office  Clinic

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_